

Case 1:18 cv 05950 DC Document 145 8 Filed 03/01/24 Page 1 of 24 State of New York - Workers' Compensation Board

S12790297

Subsequent Report of Injury Report Type (MTC) SA-Sub-Annual

This paper contains information that has been provided electronically to the Board. Do <u>not</u> serve a copy of this on the Board.

Employee Name EDWARD PI	TRE						
WCB Case Number (JCN) G1	292951			Date of	Injury <u>02/27/2</u>	015	
Claim Administrator Claim Num	nber <u>W0571</u>	595369		Maintenance Type Code Date 01/11/2024			
				WCB R	eceived Date	01/11/2024	
		INS	JRER INFORM	IATION			
FEIN xxxxx6505					Insurer ID	W846505	
	Cl	AIM ADM	INISTRATOR	INFORMA	TION		
Name POLICE, FIRE, SAN, C	CORR, CITY OI	= NY			FEIN	xxxxx6505	
Claim Representative Name PA	AULA FELICIEN	١			Postal Code	11201	
Claim Representative Business	Phone Number	er <u>71872</u>	45546				
E-mail Address PFELICIE@LAV	V.NYC.GOV					Claim Admin	ID <u>W846505</u>
		EMPL	OYEE INFOR	MATION			
First Name EDW	/ARD				Middle Name/I	nitial	
Last Name PITR	E				Suffix		
Date of Birth 02/28	3/1971						
Employee ID Type S - E	mployee Socia	l Security Nu	mber		Employee ID	xxxxx327	1
			BENEFITS				
Overpayment Amount - Current	i						
Benefits							
Benefit Types							
030 - Permanent Partial/Sched	luled						
050 - Temporary Total							
070 - Temporary Partial							
Benefit Type Date Date Code Date Date	Claim Claim Weeks Days	<u>W</u> Effective Date	eekly Gross Amount	Effective Date	Weekly Net Amount	Benefit Payment Issue Date	Amount Paid

Benefit Type	Start Date	Through Date	Claim Weeks	Claim Days	Amount Paid
030 - Permanent Partial/Scheduled	02/28/2015	04/23/2018	164	1	\$699.47
050 - Temporary Total	02/28/2015	03/11/2019	139	0	\$97,750.13
070 - Temporary Partial	12/08/2015	05/26/2019	92	2	\$63,960.26

Benefit Type	Type Adjustment/Credit/Redistribution	Start Date End Date Weekly Amount

Other Benefits

Other Benefit Type	Amount	Other Benefit Type	Amount
340 - Total Claimant's Legal Expenses	\$11,475.00	350 - Total Payments to Physicians	\$803.00
370 - Total Other Medical	\$26,597.34	450 - Total Pharmaceutical Costs	\$965.65
460 - Total Physical Therapy Costs	\$2,986.43		

Recoveries

Amount

Name	Contact Business Phone	Wage	



Case 1:18 cv 05950 DC Document 145 8 Filed 03/01/24 Page 3 of 24 State of New York - Workers' Compensation Board

S12165875

Subsequent Report of Injury Report Type (MTC) SA-Sub-Annual

This paper contains information that has been provided electronically to the Board. Do <u>not</u> serve a copy of this on the Board.

Employee Name EDWARD	PITRE						
WCB Case Number (JCN)	1292951			Date of	Injury <u>02/27/2</u>	015	
Claim Administrator Claim Nu	mber <u>W0571</u>	595369		Maintenance Type Code Date 07/15/2023			
				WCB R	eceived Date	07/15/2023	
		INS	URER INFORM	IATION			
FEIN xxxxx6505		-			Insurer ID	W846505	
	C	LAIM ADM	IINISTRATOR	INFORMAT	ION		
Name POLICE, FIRE, SAN,	CORR, CITY O	FNY			FEIN	xxxxx6505	
Claim Representative Name F	AULA FELICIEI	N			Postal Code	11201	
Claim Representative Busines	s Phone Numb	er _71872	45546				
E-mail Address PFELICIE@LA	.W.NYC.GOV					Claim Admin	ID <u>W846505</u>
		EMPL	OYEE INFOR	MATION			
First Name ED	WARD				Middle Name/l	nitial	
Last Name PIT	RE				Suffix		
Date of Birth 02/	28/1971						
Employee ID Type S-	Employee Socia	l Security Nu	mber		Employee ID	xxxxx327	1
			BENEFITS				
Overpayment Amount - Curre	nt						
Benefits							
Benefit Types							
030 - Permanent Partial/Sch	eduled						
050 - Temporary Total							
070 - Temporary Partial							
Benefit Type Code Start Date Date	Claim Claim Weeks Days	Effective Date	Amount	Effective Date	Weekly Net Amount	Benefit Payment Issue Date	Amount Paid

Benefit Type	Start Date	Through Date	Claim Weeks	Claim Days	Amount Paid
030 - Permanent Partial/Scheduled	02/28/2015	04/23/2018	164	1	\$699.47
050 - Temporary Total	02/28/2015	03/11/2019	139	0	\$97,750.13
070 - Temporary Partial	12/08/2015	05/26/2019	92	2	\$63,960.26

Benefit Type	Type	Adjustment/Credit/Redistribution	Start Date End Date	Weekly Amount
	' ' ' ' ' '			

Other Benefits

Other Benefit Type	Amount	Other Benefit Type	Amount
340 - Total Claimant's Legal Expenses	\$11,475.00	350 - Total Payments to Physicians	\$803.00
370 - Total Other Medical	\$26,597.34	450 - Total Pharmaceutical Costs	\$965.65
460 - Total Physical Therapy Costs	\$2,986.43		

Recoveries

Recovery Type	

Name	Contact Business Phone	Wage	



Case 1:18 cv 05950 DC Document 145 8 Filed 03/01/24 Page 5 of 24 State of New York - Workers' Compensation Board

S9603617

Subsequent Report of Injury Report Type (MTC) SA-Sub-Annual

This paper contains information that has been provided electronically to the Board. Do not serve a copy of this on the Board.

Name Police Fire San Number Police Fire San Number Police Fire San Number Police	Employ	ee Name _E	EDWARD F	PITRE								
Agreement to Compensate	WCB C	ase Number	(JCN) G	1292951				Date	Date of Injury 02/27/2015			
NSURER INFORMATION	Claim A	dministrato	r Claim Nui	nber _	W05715	595369		Main	tenance Type Co	de Date _08/20	/2021	
INSURER INFORMATION								WCB	Received Date	08/20/2021		
CLAIM ADMINISTRATOR INFORMATION	Agreem	ent to Comp	pensate L	· With Lia	ability							
Name						INSL	JRER INFOR	MATION				
Name	FEIN x	xxxx6505							Insurer ID	W846505		
Claim Representative Name					CL	MGA MIA.	INISTRATOR	INFORM	ATION			
Business Phone Number 7187245546 Fax Number E-mail Address PFELICIE®LAW.NYC.GOV Claim Admin ID W846505 EMPLOYEE INFORMATION First Name EDWARD Middle Name/Initial Last Name PITRE Suffix Date of Birth 02/28/1971 Employee ID Type S - Employee Social Security Number Employee ID Type Benefits Benefit Types 030 - Permanent Partial/Scheduled 050 - Temporary Total 070 - Temporary Partial Benefit Types Date Rate Through Claim Claim Weekly Gross Date Weekly Gross Date Refrective Effective Effective Payment Pagid	Name	POLICE, F	FIRE, SAN,	CORR, (CITY OF	NY			FEIN	xxxxx6505		
E-mail Address PFELICIE@LAWNYC.GOV EMPLOYEE INFORMATION First Name EDWARD Middle Name/Initial Last Name PITRE Suffix Suffix Date of Birth 02/28/1971 Employee ID Type S - Employee Social Security Number BENEFITS Benefits Benefit Types 030 - Permanent Partial/Scheduled 050 - Temporary Total 070 - Temporary Partial Benefit Types Start Through Claim Weekly Gross Date Meekly Gross Effective Effective Effective Benefit Payment Payment Payd Amount Paid	Claim Representative Name PAULA FELICIEN				Postal Code	11201						
First Name EDWARD Middle Name/Initial Last Name PITRE Suffix Date of Birth 02/28/1971 Employee ID Type S - Employee Social Security Number Employee ID BENEFITS Benefits Benefit Types 030 - Permanent Partial/Scheduled 050 - Temporary Total 070 - Temporary Partial Benefit Type Pate Date Date Weeks Days Effective Effective Effective Payment Paid	Busines	ss Phone Nu	mber <u>7</u>	1872455	46				Fax Number			
First Name	E-mail /	Address PFE	ELICIE@LA	W.NYC.	GOV					Claim Admin	ID _W846505	
Last Name PITRE Suffix Date of Birth 02/28/1971 Employee ID Type S - Employee Social Security Number Employee ID xxxxx3271 BENEFITS Benefits Benefit Types 030 - Permanent Partial/Scheduled 050 - Temporary Total 070 - Temporary Partial Benefit Types Start Through Claim Claim Weekly Gross Effective Effective Effective Effective Effective Date Date Date Date Weeks Dave Effective Effective Suffix Weekly Net Benefit Payment Partial						EMPL	OYEE INFO	RMATION				
Date of Birth C2/28/1971 Employee ID Type S - Employee Social Security Number Employee ID Type BENEFITS Benefits Benefit Types 030 - Permanent Partial/Scheduled 050 - Temporary Total 070 - Temporary Partial Benefit Types Start Through Date Weeks Days Effective Effective Weekly Gross Employee ID xxxxx3271 Employee ID xxxxxx3271 Employee ID xxxxxx3271 Employee ID xxxxxx3271 Employee ID xxxxxx3271 Benefit Senefit Types Oxide ID Type ID Ty	First Na	ame	EDV	VARD					Middle Name/l	nitial		
Benefit Types 030 - Permanent Partial/Scheduled 050 - Temporary Total 070 - Temporary Partial Benefit Types Start Through Claim Claim Weekly Gross Weekly Net Payment Payment Payment Payment Payment Payment Payment Payment Pagind	Last Na	ıme	PITI	RE					Suffix			
Benefits Benefit Types 030 - Permanent Partial/Scheduled 050 - Temporary Total 070 - Temporary Partial Benefit Type Start Through Claim Claim Weekly Gross Weekly Net Payment Paid	Date of	Birth	02/2	8/1971								
Benefit Types 030 - Permanent Partial/Scheduled 050 - Temporary Total 070 - Temporary Partial Benefit Types Weekly Gross Weekly Net Benefit Payment Paym	Employ	ee ID Type	<u>S-I</u>	S - Employee Social Security Number					Employee ID	_xxxxx327	<u>'1 </u>	
Benefit Types 030 - Permanent Partial/Scheduled 050 - Temporary Total 070 - Temporary Partial Benefit Start Through Claim Claim Weekly Gross Weekly Net Benefit Payment Paid							BENEFITS	Y				
030 - Permanent Partial/Scheduled 050 - Temporary Total 070 - Temporary Partial Benefit Type Date Date Date Weeks Days Effective Effective Effective Effective	Benet	fits										
050 - Temporary Total 070 - Temporary Partial Benefit Start Through Claim Claim Weekly Gross Weekly Net Benefit Payment Paid	Benefi	it Types										
070 - Temporary Partial Benefit Start Through Claim Claim Weekly Gross Weekly Net Benefit Payment Paid	030 -	- Permanent l	Partial/Sche	duled								
Benefit Type Date Date Weeks Days Effective Effective Benefit Payment Paid	050 -	- Temporary	Γotal									
Type Start I nrough Claim Claim Effective Effective Payment Paid	070 -	- Temporary F	Partial									
	Type		00000000000000000 0 000000			Effective)	Payment		

Benefit Type	Start Date	Through Date	Claim Weeks	Claim Days	Amount Paid
030 - Permanent Partial/Scheduled	02/28/2015	04/23/2018	164	1	\$699.47
050 - Temporary Total	02/28/2015	03/11/2019	139	0	\$97,750.13
070 - Temporary Partial	12/08/2015	05/26/2019	92	2	\$63,960.26

Benefit Type	Type	Adjustment/Credit/Redistribution	Start Date End Date	Weekly Amount
Deficit Type	'	riajusimenti Oreatiti realismouton	Start Date Life Date	Weekly Millouit
				!

Other Benefits

Other Benefit Type	Amount	Other Benefit Type	Amount
340 - Total Claimant's Legal Expenses	\$11,475.00	350 - Total Payments to Physicians	\$338.00
370 - Total Other Medical	\$26,597.34	450 - Total Pharmaceutical Costs	\$965.65
460 - Total Physical Therapy Costs	\$2,986.43		

Recoveries

Recovery Type	Amount

Name	Contact Business Phone	Wage	



Case 1:18 cv 05950 DC Document 145 8 Filed 03/01/24 Page 7 of 24 State of New York - Workers' Compensation Board

S8196118

Subsequent Report of Injury Report Type (MTC) SA-Sub-Annual

This paper contains information that has been provided electronically to the Board. Do <u>not</u> serve a copy of this on the Board.

Employee Name _EDWA	RD PITRE							
WCB Case Number (JCN)	G1292951			Date o	f Injury <u>02/27/2</u>	015		
Claim Administrator Clair	m NumberW057	1595369		Maintenance Type Code Date 08/20/2020				
				WCB F	Received Date	08/20/2020		
Agreement to Compensa	te L - With Liability			_				
		INSU	JRER INFORM	IATION				
FEIN xxxxx6505		_			Insurer ID	W846505		
	C	LAIM ADM	INISTRATOR	NFORMA	TION			
Name POLICE, FIRE,	SAN, CORR, CITY (OF NY			FEIN	xxxxx6505		
Claim Representative Name PAULA FELICIEN					Postal Code	11201		
Business Phone Number	7187245546				Fax Number			
E-mail Address PFELICIE	@LAW.NYC.GOV					Claim Admir	N846505	
		EMPL	OYEE INFOR	MATION				
First Name	EDWARD				Middle Name/l	nitial		
Last Name	PITRE				Suffix			
Date of Birth	02/28/1971							
Employee ID Type	S - Employee Soci	S - Employee Social Security Number			Employee ID	xxxxx32	271	
			BENEFITS					
Benefits								
Benefit Types								
030 - Permanent Partial	/Scheduled							
050 - Temporary Total								
070 - Temporary Partial								
	ough Claim Clain ate Weeks Days	ור <u></u>	eekly Gross Amount	Effective Date	Weekly Net Amount	Benefit Payment Issue Date	Amount Paid	

Benefit Type	Start Date	Through Date	Claim Weeks	Claim Days	Amount Paid
030 - Permanent Partial/Scheduled	02/28/2015	04/23/2018	164	1	\$699.47
050 - Temporary Total	02/28/2015	03/11/2019	139	0	\$97,750.13
070 - Temporary Partial	12/08/2015	05/26/2019	92	2	\$63,960.26

Benefit Type	Type Adjustment/Credit/Redistribution	Start Date End Date Weekly Amount

Other Benefits

Other Benefit Type	Amount	Other Benefit Type	Amount
340 - Total Claimant's Legal Expenses	\$11,475.00	350 - Total Payments to Physicians	\$338.00
370 - Total Other Medical	\$26,597.34	450 - Total Pharmaceutical Costs	\$965.65
460 - Total Physical Therapy Costs	\$2,986.43		

Recoveries

Recovery Type	

Name	Contact Business Phone	Wage	



Case 1:18-cv-05950-DC Document 145-8 Filed 03/01/24 Page 9 of State of New York - Workers' Compensation Board

S6568718

Subsequent Report of Injury Report Type (MTC) PY-Payment Report

This paper contains information that has been provided electronically to the Board. Do not serve a copy of this on the Board. The Claim Administrator has made payment(s) as reflected in Benefits and/or Payments Section of this document.

Employee Name EDWA	RD PITRE			
WCB Case Number (JCN)	G1292951		Date of Injury 02/27/2	015
Claim Administrator Clain	m Number <u>W057</u>	1595369	Maintenance Type Cod	de Date <u>05/24/2019</u>
Claim Type L - Became Ir	ndemnity for Lost Tir	me	WCB Received Date	05/24/2019
Agreement to Compensat	te L - With Liability			
		INSURER INFORMAT	ION	
FEIN xxxxx6505		_	Insurer ID	W846505
	C	LAIM ADMINISTRATOR INF	ORMATION	
Name POLICE, FIRE, S	SAN, CORR, CITY C	DF NY	FEIN	xxxxx6505
Claim Representative Nar	me PAULA FELICIE	N	Postal Code	11201
Business Phone Number	7187245546		Fax Number	
E-mail Address PFELICIE	@LAW.NYC.GOV			Claim Admin ID W846505
Late Reason				
		EMPLOYEE INFORMA	TION	
First Name	EDWARD		Middle Name/l	nitial
Last Name	PITRE		Suffix	
Date of Birth	02/28/1971			
Employee ID Type	S - Employee Soci	al Security Number	Employee ID	xxxxx3271
		CLAIM INFORMATIO	N	
Date Employer Had Know	rledge of Date of Di	sability 03/27/2015	Employment Status	1 - Regular/Full-time Employee
Pre-existing Disability	-	No O M T W T F O	Number of Days Wo	orked Per Week 5
Work Days Scheduled (S-	Scheduled N-Non Sch	SMTWTFS eduled)	Work Week Type	
Calculated Wage	-	\$2,597.80	Wage Period	01 - Weekly
Calculated Weekly Compe	ensation Amount	\$808.65	Denial Rescission I	Date
Employer Paid Salary Price	or To Acquisition			
Date Claim Administrator	Notified of Employ	ee Representation		

EMPLOY	ŒE INJ	URY										
Full Wages	Paid for	Date of Inju	ıry <u>Y</u>	es_				Employe	r Paid Salary	in Lieu of Comp	ensation	No
Type of Los	ss <u>01</u> -	Traumatic Ir	njury					Date of M	laximum Med	lical Improvemen	nt	
PERMANEI	NT IMPA	IRMENT										
Impairment	Percent	age_35.0%		Body	Part 33	3 - Lower	Arm					
Impairment	Percent	age <u>22.50%</u>		Body	Part 35	5 - Hand						
Death Resu	ılt of Inju	iry		Date	of Death	ı		Number	of Dependent	s <u>9</u>		
Dependent/	Payee R	elationship										
WORK S	TATUS	3										
First Day of	Disabili	ty After The	Waitin	g Peric	od 02/28/	2015		Lates	st Return to V	Vork Status Date	04/13/201	5
Initial Date	Disabilit	y Began	02/28/2	2015								
Initial Retur	n to Wo	rk Date	03/04/2	2015								
Return To V	Vork Typ	De <u>A - Ac</u>	tual	F	hysical l	Restrictio	ns No	Retui	rn To Work S	ame Employer	Yes	
BENEFITS												
Reduced Be	enefit An	nount R-	Reclass	ification	n of Bene	fit						
Estimated 0	31055 VV	eekiy Aiiit.		_								
Benefits Benefit Ty	***************************************					***************************************						000000000000000000000000000000000000000
		Partial/Sched	duled			***************************************						
050 - Ter												
070 - Ter	mporary F	Partial										
13/MP	Start Oate	Through Date	Claim Weeks	Claim Days	Effecti Date		Gross mount	Effective Date	Weekly Net Amount	Benefit Payment Issue Date	Amo Pa	
030 02/2	28/2015	04/23/2018	164	1	02/28/20	015	\$808.65	02/28/2015	\$80	05/22/2019		\$699.47
050 02/2	28/2015	03/11/2019	139	0	09/14/20	015	\$808.65	09/14/2015	\$80	08.65 08/19/2018	\$97	7,750.13
Benefits -	· Cumu	lative								·		
		Benefit Type	9			Start Date	Through Date	n Claim Weeks	,	Amount Paid		
070 - Tempo	orary Par	tial				12/08/201			2	\$63,960.26	6	
Benefits -	. Δ . Δ.	diustmant	's / C -	Cred	ite / R -	Redistr	rihutione					
Dellelles -		-	.g , .g -	oreu.				t(Dadistriburt	61_4.1	Doto Full Date	V84m etak	A
	ь	enefit Type			Туре	Aaju	stment/Credi	vreuistiibuli	on Start I	Date End Date	Weekly	mnount

Other Benefits

Other Benefit Type	Amount	Other Benefit Type	Amount
340 - Total Claimant's Legal Expenses	\$11,475.00	350 - Total Payments to Physicians	\$338.00
370 - Total Other Medical	\$25,998.82	450 - Total Pharmaceutical Costs	\$965.65
460 - Total Physical Therapy Costs	\$2,986.43		

ward/Ord	ei Date	Lump Sum Payme	invoettiement	AW - Award			
Paymen	t Reasons						
030 - F	Permanent Partial/Scheduled						
050 - T	emporary Total						
Payment eason Co	de Pay	ee	Start Date	Through Date	Issue Date	Amount Paid	
030	EDWARD PITRE		02/28/2015	04/23/2018	05/22/2019	\$699.47	
050	EDWARD PITRE		04/24/2018	03/11/2019	05/22/2019	\$9,560.36	
ecoveri							

EMPLOYER / INSURED INFORMATION Employer FEIN xxxxxx6505 Insured FEIN xxxxxx6505 CONCURRENT EMPLOYER INFORMATION Name Contact Business Phone Wage



Case 1:18 cv 05950 DC Document 145-8 Filed 03/01/24 Page 12 of 24 State of New York - Workers' Compensation Board

S5598069

Subsequent Report of Injury Report Type (MTC) SA-Sub-Annual

This paper contains information that has been provided electronically to the Board. Do not serve a copy of this on the Board.

Employ	ee Name	EDWARD P	ITRE								
WCB C	ase Number	(JCN) G1	292951				Date o	f Injury <u>02/27/2</u>	015		
Claim A	dministrato	or Claim Nun	nber	W05715	95369		Mainte	nance Type Co	de Date <u>08/20/</u>	2018	
							WCB F	Received Date	08/20/2018		
					INSU	RER INFORI	MATION				
FEIN <u>x</u>	xxxx6505							Insurer ID	W846505		
				CL	AIM ADMI	NISTRATOR	INFORMA	TION			
Name	POLICE,	FIRE, SAN, (CORR, (CITY OF	NY			FEIN	xxxxx6505		
Claim R	Representati	ve Name P	AULA FE	ELICIEN				Postal Code	11201		
Busines	ss Phone Nu	umber 71	872455	46				Fax Number			
E-mail /	Address PF	ELICIE@LA\	W.NYC.	GOV					Claim Admin II	D <u>W846505</u>	
					EMPL	OYEE INFOR	RMATION				
First Na	ame	EDV	VARD					Middle Name/I	nitial		
Last Na	ıme	PITE	RE					Suffix			
Date of	Birth	02/2	8/1971								
Employ	ee ID Type	<u>S-E</u>	Employee	e Social	Security Nun	nber		Employee ID	xxxxx327	1	
	000000000000000000000000000000000000000					BENEFITS					
Benet	fits										
Benefi	t Types										
050 -	Temporary	Total									
070 -	Temporary	Partial									
Benefit Type Code	Start Date	Through Date	Claim Weeks	Claim Days	<u>We</u> Effective Date	ekly Gross Amount	Effective Date	Weekly Net Amount	Benefit Payment Issue Date	Amount Paid	

D	Start	Through	Claim	Claim	Amount
Benefit Type	Date	Date	Weeks	Days	Paid
050 - Temporary Total	02/28/2015	08/19/2018	109	4	\$88,189.77

Benefit Type	Start	Through	Claim	Claim	Amount
	Date	Date	Weeks	Days	Paid
070 - Temporary Partial	12/08/2015	11/12/2017	52	2	\$36,400.26

Benefit Type	Туре	Adjustment/Credit/Redistribution	Start Date End Date	Weekly Amount

Other Benefits

Other Benefit Type	Amount	Other Benefit Type	Amount
340 - Total Claimant's Legal Expenses	\$5,100.00	350 - Total Payments to Physicians	\$338.00
370 - Total Other Medical	\$25,840.99	450 - Total Pharmaceutical Costs	\$965.65
460 - Total Physical Therapy Costs	\$2,986.43		

Recoveries

Recovery Type

300000000000000000000000000000000000000		EMPL OVE	P / INISTIR	ED INFORMATION	

Amount

CONCURRENT EMPLOYER INFORMATION Name _____ Contact Business Phone _____ Wage _____



Case 1:18 cv 05950 DC Document 145-8 Filed 03/01/24 Page 14 of 24 State of New York - Workers' Compensation Board

S3714160

Subsequent Report of Injury Report Type (MTC) SA-Sub-Annual

This paper contains information that has been provided electronically to the Board. Do <u>not</u> serve a copy of this on the Board.

Employ	ee Name	EDWARD P	ITRE								
WCB C	ase Numbe	r (JCN) G1	292951				Date o	f Injury <u>02/27/2</u>	2015		
Claim A	dministrat	or Claim Nun	nber	W05715	95369		Mainte	nance Type Co	de Date <u>02/27/</u>	2017	
							WCB F	Received Date	02/27/2017		
					INSU	RER INFORI	MATION				
FEIN <u>x</u>	xxxx6505							Insurer ID	W846505		
				CL	AIM ADMI	NISTRATOR	INFORMA	TION			
Name	POLICE,	FIRE, SAN,	CORR, (CITY OF	NY			FEIN	xxxxx6505		
Claim R	Representat	tive Name P	AULA FE	ELICIEN				Postal Code	11201		
Busines	ss Phone N	lumber 71	1872455	46				Fax Number			
E-mail /	Address								Claim Admin II	D <u>W846505</u>	
1000100010001000					EMPL	OYEE INFOR	RMATION				
First Na	ame	EDV	VARD					Middle Name/l	nitial		
Last Na	ıme	PITE	RE					Suffix			
Date of	Birth	02/2	8/1971								
Employ	ee ID Type	S-E	Employee	e Social	Security Nur	nber		Employee ID xxxxxx3271			
						BENEFITS					
Benet	fits										
Benefi	it Types										
050 -	- Temporary	[,] Total									
070 -	- Temporary	[,] Partial									
Benefit Type Code	Start Date	Through Date	Claim Weeks	Claim Days	<u>We</u> Effective Date	ekly Gross Amount	Effective Date	Weekly Net Amount	Benefit Payment Issue Date	Amount Paid	

Decesia Time	Start	Through	Claim	Claim	Amount
Benefit Type	Date	Date	Weeks	Days	Paid
050 - Temporary Total	02/28/2015	03/05/2017	48	3	\$38,700.39

Benefit Type	Start	Through	Claim	Claim	Amount
	Date	Date	Weeks	Davs	Paid
070 - Temporary Partial	12/08/2015	07/20/2016	32	2	\$21,900.26

Benefit Type	Туре	Adjustment/Credit/Redistribution Start Date End Date Weekly Amount

Other Benefits

Other Benefit Type	Amount	Other Benefit Type	Amount
340 - Total Claimant's Legal Expenses	\$4,900.00	370 - Total Other Medical	\$13,957.53
450 - Total Pharmaceutical Costs	\$965.65	460 - Total Physical Therapy Costs	\$2,688.44

Recoveries

Employer FEIN	xxxxx6505			
		PLOYER / INSU	JRED INFORMATION	

Amount

CONCURRENT EMPLOYER INFORMATION

Recovery Type

Name	Contact Business Phone	Wage



Case 1:18-cv-05950-DC Document 145-8 Filed 03/01/24 Page 16 of 24 State of New York - Workers' Compensation Board

F1824709

First Report of Injury Report Type (MTC) 02-Change

This paper contains information that has been provided electronically to the Board. Do not serve a copy of this on the Board.

Pursuant to 12 NYCRR §300.22, when the claim administrator is changing the Denial Reason, this notice must be served on the claimant and his or her attorney or licensed representative, if any, within one business day of the date it is filed electronically with the chair.

Employee Name EDWARD PITRE						
WCB Case Numb	er (JCN) G1292951	Date of Injury	02/27/2015			
Claim Administra	tor Claim Number W0571595369	Maintenance	Type Code Da	ote 03/02/2016		
Claim Type L - Be	ecame Lost Time	WCB Receive	d Date 03/02	2016		
	INSURER INFORMAT	ION				
Insurer Name PC	DLICE, FIRE, SAN, CORR, CITY OF NY	FEIN	xxxxx6505			
Insurer Type S-	Self-Insurer	Insurer ID	W846505			
	CLAIM ADMINISTRATOR INF	ORMATION				
Name POLICE	E, FIRE, SAN, CORR, CITY OF NY					
Info/Attn NYC LA	w Department-Workers Compensation Divi					
Address 350 JAY	STREET					
City	BROOKLYN	State		NY		
Postal Code	11201	Count	ry	US - UNITED STATES		
FEIN	xxxxx6505	Claim	Admin ID	W846505		
Late Reason						
FULL DENIAL REASONS						
Full Denial Effective Date						
Full Denial Reason						
Denial Reason Na	arrative					

		EMPL	OYEE INFORMATION		
First Name	EDWARD			Middle Name/Initia	I
Last Name	PITRE			Suffix	
Mailing Address	130-59 11	5TH STREET			
City	SOUTH C	ZONE PAR		State	NY
Postal Code	11420			Country	US - UNITED STATES
Phone Number				Gender	M - Male
Date of Birth	02/28/197	1		Date of Hire	
Employee ID Type	e _S	5 - Employee Social Security Nu	umber	Employee ID	xxxxx3271
Occupation Desc	ription <u>C</u>	OMMUNICATION ELECTRICI	AN		
		CIL	AIM INFORMATION		
Time of injury			Date Employer Had Kno	owledge of the Injury	02/27/2015
Employment Stat	:us <u>7-0t</u>	ner	Date Claim Administrat	or Had Knowledge of t	he Injury_03/27/2015
Wage Period	01 - W	eekly	Date Employer Had Kno	owledge of Date of Disa	ability 02/28/2015
Estimated Wage	\$2,59	7.80	Number of Days Worke	d Per Week	
Work Week Type			Work Days Scheduled	(S-Scheduled N-Non Sch	s M T W T F S
EMPLOYEE IN	JURY				
Full Wages Paid 1	for Date o	f Injury Yes	Employer Paid Salary in	n Lieu of Compensatio	n <u>No</u>
Death Result of Ir	njury		Date of Death	Numbe	r of Dependents 9
Nature of Injury	49 -	Sprain or Tear			
Part of Body	<u>31 -</u>	Upper Arm			
Cause of Injury	27 -	Fall, Slip or Trip Injury - From I	Liquid or Grease Spills		
Type of Loss	01 -	Traumatic Injury			
	THAT WH	1 IILE WORKING ON L126, HE (HE DISMOUNTED THE VEHIC		HE POST ON WEST 158	TH STREET AND
WORK STATU	'S				
Initial Date Last D	ay Worke	ed	Retur	n To Work Type	A - Actual
Initial Date Disab	ility Bega	n 02/28/2015	Physi	cal Restrictions	No
Initial Return to V	Vork Date	03/04/2015	Retur	n To Work Same Empl	oyer Yes

	ACCIDENT LOCATION AND WITNE	SSES	
Premises	X - Other		
Organization Nan	ne		
Street	158TH ST AND AMSTERDAM AVE	State	NY
City	NEW YORK	Postal Code	10032
County/Parish	NEW YORK - New York	Country	US - UNITED STATES
Location Narrativ	e 158TH ST AND AMSTERDAM AVE NEW YORK NY		
	Witnesses	Business Ph	none Number
	MEDICAL TREATMENT		
Initial Treatment	3 - Emergency Evaluation, Diagnostic Testing, and Medical Proce	edures	
Managed Care Or	g.		
Managed Care Or			
	EMPLOYER INFORMATION		
Name FIRE DEP	APTMENT	Employer FEIN	xxxxx6505
Industry Code	921190	UI Number	- Manual Cook
Manual Classifica			
Info/Attn	of to - Mulliopal, Township, County of Otate Employee Noc		
-	9 METROTECH PLAZA 2ND FLOOR		
	BROOKLYN	State	NY
-	11201	Country	US - UNITED STATES
-	9 METROTECH PLAZA 2ND FLOOR	•	
-	BROOKLYN	State	NY
-	11201	Country	US - UNITED STATES
-	MAUREEN SOMMA	- -	
- Jonean Hallie	THE CONTRACT		

Contact Business Phone Number 7189991845

	INSURED INFORMATION		
Insured Name FIRE D	EPARTMENT	Insured FEIN	xxxxx6505
Insured Type	S - Self-Insured	Insured Location ID	1586
Policy Number ID			
Policy Effective Date		Policy Expiration Date	!



Case 1:18-cy-05950-DC Document 145-8 Filed 03/01/24 Page 20 of 24 State of New York - Workers' Compensation Board

F1102358

First Report of Injury Report Type (MTC) 00-Original

This paper contains information that has been provided electronically to the Board. Do not serve a copy of this on the Board.

Employee Name	EDWARD PITRE				
WCB Case Numb	per (JCN) G1292951	Date of Injury 02/27/201	Date of Injury 02/27/2015		
Claim Administra	ator Claim Number <u>W0571595369</u>	Maintenance Type Cod	e Date 04/09/2015		
Claim Type M - N	Medical Only	WCB Received Date _0	4/10/2015		
	INSURER INFO	RMATION			
Insurer Name PC	DLICE, FIRE, SAN, CORR, CITY OF NY	FEIN xxxxx650	5		
Insurer Type S	- Self-Insurer	Insurer ID W846505	5		
	CLAIM ADMINISTRATO	RINFORMATION			
Name POLICI	E, FIRE, SAN, CORR, CITY OF NY				
Info/Attn NYC La	aw Department-Workers Compensation Division				
Address 350 JA	Y STREET				
City	BROOKLYN	State	NY		
Postal Code	11201	Country	US - UNITED STATES		
FEIN	xxxxx6505	Claim Admin ID	W846505		
Late Reason					
	EMPLOYEE INFO	ORMATION			
First Name	EDWARD	Middle Name/In	itial		
Last Name	PITRE	Suffix			
Mailing Address	130-59 115TH STREET				
City	SOUTH OZONE PAR	State	NY		
Postal Code	11420	Country	US - UNITED STATES		
Phone Number		Gender	_M - Male		
Date of Birth	02/28/1971	Date of Hire			
Employee ID Typ	S - Employee Social Security Number	Employee ID	xxxxx3271		
Occupation Desc	cription COMMUNICATION ELECTRICIAN				

	CL	AIM INFORMATION	
Time of injury		Date Employer Had Knowledge of the Injury	02/27/2015
Employment Status	7 - Other	Date Claim Administrator Had Knowledge of the Inju	ry 03/27/2015
Wage Period	01 - Weekly	Date Employer Had Knowledge of Date of Disability	03/27/2015
Estimated Wage	\$1,666.00	Number of Days Worked Per Week	
Work Week Type		Work Days Scheduled (S-Scheduled N-Non Scheduled)	SMTWTFS
EMPLOYEE INJU	JRY		
Full Wages Paid for	Date of Injury Yes	Employer Paid Salary in Lieu of Compensation	No
Death Result of Inju	ry	Date of Death Number of De	pendents <u>9</u>
Nature of Injury	49 - Sprain or Tear		
Part of Body	31 - Upper Arm		
Cause of Injury	27 - Fall, Slip or Trip Injury - From L	_iquid or Grease Spills	
Type of Loss	01 - Traumatic Injury		
		MR.PITRE) ARRIVED AT THE POST ON WEST 158TH STE LE	REET AND
WORK STATUS			
Initial Date Last Day	Worked	Return To Work TypeA	- Actual
Initial Date Disabilit	y Began _03/19/2015	Physical Restrictions N	lo
Initial Return to Wo	rk Date 03/04/2015	Return To Work Same Employer Y	es
	ACCIDENT I	LOCATION AND WITNESSES	
Premises	X - Other		
Organization Name			_
Street	158TH ST AND AMSTERDAM AVE	State NY	
City	NEW YORK	Postal Code 10032	2
County/Parish	NEW YORK - New York	Country US - U	JNITED STATES
Location Narrative	158TH ST AND AMSTERDAM AVE N	IEW YORK NY	
	Witnesses	Business Phone Nu	ımber

	MEDICAL TREATMENT		
Initial Treatment	3 - Emergency Evaluation, Diagnostic Testing, and Medical Proce	dures	
Managed Care O	rg		
Managed Care O	rg. ID		
	EMPLOYER INFORMATION		
Name FIRE DEF	PARTMENT	Employer FEIN	xxxxx6505
Industry Code	921190	UI Number	
Manual Classifica	ation 9410 - Municipal, Township, County Or State Employee Noc		
Info/Attn			
Mailing Address	9 METROTECH PLAZA 2ND FLOOR		
City	BROOKLYN	State	NY
Postal Code	11201	Country	US - UNITED STATES
Physical Addr	9 METROTECH PLAZA 2ND FLOOR		
City	BROOKLYN	State	NY
Postal Code	11201	Country	US - UNITED STATES
Contact Name	MAUREEN SOMMA		
Contact Business	s Phone Number <u>7189991845</u>		
	INSURED INFORMATION		
Insured Name FI	RE DEPARTMENT	Insured FEIN	xxxxx6505
Insured Type	S - Self-Insured	Insured Location ID	1586
Policy Number ID			
Policy Effective D	Date	Policy Expiration D	ate



Employee Claim 5 State of New York - Workers' Compensation Board

5082111281

Fill out this form to apply for workers' compensation benefits because of a work injury or work-related illness. Type or print neatly. This form may also be filled out on-line at www.wcb.ny.gov.

AA.	CB Case Number (if you know it):				
Α.	. YOUR INFORMATION (Employee) 1. Name: Edward Pitre	2. Date of B	irth: <u>02/28/1</u>	971	
	F r St MI Last				
	3. Mailing address: 130-59 115th Street Queens, NY 11420 Number and Street/PO Box City	State	Zip Code		
	4. Social Security Number: 121-60-3271 5. Phone Number: (732) 801-	0347 6. Gende	er: X Male	☐ Female	
	7. Will you need a translator if you have to attend a Board hearing? Yes No If	es, for what language?	?		
	YOUR EMPLOYER(S)				
	Employer when injured: NYC Fire Department	2. Phone Numbe	r: <u>(718) 62</u>	4-2370	
	3. Your work address: 9 Metro Tech Plaza, Brooklyn, NY 11201 Number and Street City		State	Zip Code	
	4. Date you were hired: 5. Your supervisor's name:				
	6. List names/addresses of any other employer(s) at the time of your injury/illness:				
C.	7. Did you lose time from work at the other employment(s) as a result of your injury/illness? Your Sommunication				
	1. What was your job title or description? Wire Communication				
	2. What types of activities did you normally perform at work?				
	3. Was your job? (check one)				
_					
	/OUR INJURY OR ILLNESS 1. Date of injury or date of onset of illness: 02/27/2015 2. Time of injury:				
	Where did the injury/illness happen? (e.g., 1 Main Street, Pottersville, at the front door)				
	158st Amsterdam Street				
	4. Was this your usual work location?				
	What were you doing when you were injured or became ill? (e.g., unloading a truck, typing a report)working				
	6. How did the injury/fillness happen? (e.g., I tripped over a pipe and fell on the floor)				
	coming out of the fire truck and slipped on a mountain of ice on the sidewalk.				
	. Explain fully the nature of your injury/illness; list body parts affected (e.g., twisted left ankle and cut to forehead):				
	left wrist, left shoulder	·			

Case 1:18-cv-05950-DC Document 145-8 Filed 03/01/24 Page 24 of 24

YOUR NAME: Edward Pitre	DATE OF INJURY/ILLNESS: 1 02 8/127 / 2015			
D. YOUR INJURY OR ILLNESS continued	3.1			
8. Was an object (e.g., forklift, hammer, acid) involved in the injury/illn	ess? Yes X No If yes, what?			
 Was the injury the result of the use or operation of a licensed motor of the second of the				
If your vehicle was involved, give name and address of your motor vehicle insurance carrier:				
10. Have you given your employer (or supervisor) notice of injury/illness If yes, notice was given to: Miguel Floreia	S? X Yes No X orally X in writing Date notice given: 2/27/2015			
11. Did anyone see your injury happen? X Yes No Unknow Felix Garcia (Co-worker)	wn If yes, list names:			
E. RETURN TO WORK				
1. Did you stop work because of your injury/illness? X Yes, on what	at date? 02/27/2015 Noskip to Section F.			
2. Have you returned to work? X Yes No If yes, on what do				
	Same employer New employer Self employed			
	How often are you paid?			
F. MEDICAL TREATMENT FOR THIS INJURY OR ILLNESS	5			
1. What was the date of your first treatment?03/04/2015	None received (skip to question F-5)			
2. Were you treated on site?				
3. Where did you receive your first off site medical treatment for your injury/illness? In none received Image: Emergency Room Doctor's office Image: Clinic/Hospital/Urgent Care Image: Hospital Stay over 24 hours Name and address where you were first treated: Findling Surgical PC,				
58-50 Catalpa Avenue Ridgewood, New York 11385	Phone Number: (718) 418-4263			
4. Are you still being treated for this injury/illness?				
	Phone Number:			
5. Do you remember having another injury to the same body part or a similar illness? Yes No If yes, were you treated by a doctor? Yes No If yes, provide the names and addresses of the doctor(s) who treated you and COMPLETE AND FILE FORM C-3.3 TOGETHER WITH THIS FORM: 1996 54 1000				
6. Was the previous injury/illness work related?				
If yes, were you working for the same employer that you work for no				
I am hereby making a claim for benefits under the Workers' Compensation and accurate to the best of my knowledge and belief.	Law. My signature affirms that the information I am providing is true			
Any person who knowingly and with INTENT TO DEFRAUD presents, will be presented to, or by an insurer, or self-insurer, any information material fact, SHALL BE GUILTY OF A CRIME and subject to substantial	causes to be presented, or prepares with knowledge or belief that it n containing any FALSE MATERIAL STATEMENT or conceals any I FINES AND IMPRISONMENT.			
nployee's Signature: Print Nan	ne: Edulard PITE Date: 3/13/1			
n behalf of Employee: Print Nan An individual may sign on behalf of the employee only if he or she is legally authorize	d to do so and the employee is a minor, mentally incompetent or incapacitated.			
certify to the best of my knowledge, information and belief, formed after an inquatters asserted above have evidentiary support, or are likely to have evidentiary s	iry reasonable under the circumstances, that the allegations and other fact upport after a reasonable opportunity for further investigations or discovery.			
gnature of Attorney/Representative (if any):	Date: 3 /13 /55			
int Name: Joseph A. Romano, ESQ	Title: Attorney at Law			
	e No.: Expiration Date:/			
0 (1-11) Page 2 of 2	Expiration Date.			